

7042 CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>St Marys</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>St Marys</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <i>California</i>	<i>Life</i>	OR TOWN <i>California</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First)	(Middle)	(Last)	
<i>John</i>	<i>Abell</i>	<i>Ramsworthy</i>	
5. SEX:		6. COLOR OR RACE:	
<i>Male</i>	<i>White</i>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<i>Married Nov 5-1877</i>		<i>77 yrs.</i>	
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<i>77</i>		<i>Maryland St Marys</i>	
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
<i>U.S.A.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>James Ramsworthy</i>		<i>Catherine Cullison</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>			
17. INFORMANT & ADDRESS:			
<i>Mrs Neal Hayden Calif 200</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
331X IMMEDIATE CAUSE		4 days	
ANTECEDENT CAUSE (S)		6 weeks	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		10 years	
(A) <i>Congestive heart failure</i>			
DUE TO			
(B) <i>Cerebral hemorrhage</i>			
DUE TO			
(C) <i>General arteriosclerosis</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 10, 1955*, to *July 12, 1955*, that I last saw the deceased alive on *July 11, 1955*, and that death occurred at *1:30 A.M.* from the causes and on the date stated above.

SIGNATURE <i>[Signature]</i>	DATE SIGNED <i>7/13/55</i>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>July 15-55</i>	<i>Holy Trance</i>	<i>Great Mills Md</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>July 13/55</i>	<i>[Signature]</i>	<i>Jos C. Mounsey</i>	<i>Donardtown Md</i>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUL 18 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7043

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07044
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St. Marys</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Marys</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
<input checked="" type="checkbox"/> TOWN <u>St. Marys City</u>				TOWN <u>St. Marys City</u> <input checked="" type="checkbox"/>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>Rural</u>			
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Oscar</u>		<u>Frank</u>		<u>Bailess</u>		<u>July 23 19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>Divorced</u>	<u>1/21/1882</u>	<u>73</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>		<u>US Marines</u>		<u>Mississippi</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Frank Bailess</u>				<u>Margaret Anding</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>yes</u> <input checked="" type="checkbox"/>		<u>WW 1</u>				<u>Oceanta R. Oliver- St. Marys City, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary Thrombosis</u> DUE TO						<u>immediate</u>	
Antecedent cause(s) (b) <u>Arterio-sclerotic cardiovascular Disease</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>W. Roy Guther, M.D.</u>		<u>7/26/55</u>		<u>Arlington, National</u>		<u>Arlington, Virginia</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/26/55</u>		<u>Arlington, National</u>		<u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-25-55</u>		<u>Glenn L. Houser</u>		<u>P.B. Robinson- Leonardtown, Md.</u>			

BUREAU V. A.

JUL 28 1955

RECEIVED

7044

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ST MARY'S MARYLAND				STATE MARYLAND COUNTY ST MARY'S			
CITY (If outside corporate limits, write RURAL OR and give nearest town) AVENUE				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN AVENUE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00				STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
JAMES MITCHELL BAILEY				OF DEATH: JULY 30, 1955			
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH: SEPT. 23-1873	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMEN				10B. KIND OF BUSINESS OR INDUSTRY: WATER		11. BIRTHPLACE (State or foreign country): MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME: GEORGE C. BAILEY				14. MOTHER'S MAIDEN NAME: SUSANA LONG			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS: MRS CLIFTON DOWNS AVENUE, MD.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) Cerebral Thrombosis						1 week	
ANTECEDENT CAUSE (S) (B) Arteriosclerotic cardiovascular disease						15 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Prostatic Hypertrophy							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1948 to July 30, 1955 , that I last saw the deceased alive on July 27, 1955 , and that death occurred at 12 M. from the causes and on the date stated above.							
SIGNATURE J. G. G. G. G.		M. D. Mechanicville 8/1/55		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 8/2/55		NAME OF CEMETERY OR CREMATORY SACRED HEART		LOCATION (City, town, or county) (State) BUSHWOOD, MD.	
DATE REC'D BY LOCAL REGISTRAR 8/1/55		REGISTRAR'S SIGNATURE Clarence Hauser		24. FUNERAL DIRECTOR JOS. C. MATTINGLEY		ADDRESS LEONARDTOWN, MD.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 3 1955

BUREAU V. S.

7045

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY ST MARY'S	MARYLAND	STATE MARYLAND	COUNTY ST MARY'S
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) X AVENUE	LENGTH OF STAY (in this place) LIFE	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN AVENUE	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10		STREET ADDRESS (If rural give location) 1	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) JOSEPH	(Middle) FENNIE	(Last) BAILEY	JULY 30 1955
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: APRIL 10, 1894
9. AGE last birthday: 61 yrs.		10. BIRTHPLACE (State or foreign country): MARYLAND	
11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: JAMES C. BAILEY		14. MOTHER'S MAIDEN NAME: ELLA THOMPSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unk.) (If Yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: MRS GRACE BAILEY AVENUE, MD.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) 151X Carcinoma peritonei, liver			
ANTECEDENT CAUSE (S) Ca stomach			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: April 5, 55		19B. MAJOR FINDINGS OF OPERATION: Ca stomach, liver, lymph glands	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 5, 1955 to July 1955 ; that I last saw the deceased alive on 30th, 1955 , and that death occurred at 1030 P.M. from the causes and on the date stated above.			
SIGNATURE Quarbach		ADDRESS Leonardtown, Md. 21155	
M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 8/3/55	
NAME OF CEMETERY OR CREMATORY SACRED HEART		LOCATION (City, town, or county) (State) BUSHWOOD, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 8/1/55		REGISTRAR'S SIGNATURE Charles D. Sawyer	
24. FUNERAL DIRECTOR JOS. C. MATTINGLEY		ADDRESS LEONARDTOWN, MD.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 3 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

COUNTY St. Mary's MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) Rural - Leonardtown LENGTH OF STAY (in this place) 7 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Abel's Post Office

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY St. Mary's
CITY (If outside corporate limits, write RURAL and give nearest town) Rural - Leonardtown OR TOWN Leonardtown STREET ADDRESS (If rural, give location) Abel's Post Office

3. NAME OF DECEASED:

(First) Lucy (Middle) Moore (Last) Carey

4. DATE OF DEATH: (Month) July (Day) 9 (Year) 1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: Oct. 9, 1854

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. 95 yrs. 9 Months 8 Days 8 Hours 0 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Nashville, Tennessee

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

John Ashby Russell Wilson

14. MOTHER'S MAIDEN NAME:

Mariah Ashby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: James W. Van Word
Abell Post Office, St. Mary County, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

782.4
Immediate cause

(a) Heart failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) age

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-7-55 to 7-8-55, that I last saw the deceased alive on 7-8-55, and that death occurred at 11:00 P. m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

7/11/55 Glenn L. S. Sauer Virgo Cemetery Sandy Hook, Maryland
Donald Eckles, Hagers Ferry, West Va.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 14 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07048

7047
Item 8: Film 6182-7/29/55
CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ST MARY'S		MARYLAND		STATE MARYLAND		COUNTY ST MARY'S	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ST MARY'S CITY			
X TOWN ST MARY'S CITY		13 YRS.		X STREET ADDRESS (If rural give location) 1			
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
EDWARD DUDLEY CHASE				JULY 7, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
MALE	WHITE	MARRIED	APRIL 13, 1891	64 yrs.	2 Months	24 Days	0 Hours 0 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Civil ENG.		CONSTRUCTION		NEW YORK		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
EDWARD STANFORD CHASE				ANN ADAMS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If Yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
YES				WW1		MRS RUTH CHASE ST MARY'S CITY, MD.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE						1 hour	
(A) DUE TO Coronary Thrombosis							
ANTECEDENT CAUSE (S)						5 years	
(B) DUE TO Generalized Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1, 1955 to July 7, 1955 that I last saw the deceased alive on July 7, 1955 and that death occurred at 11:55 PM from the causes and on the date stated above.							
SIGNATURE J. H. Patrick		ADDRESS M. D. Lexington Park Md.		DATE SIGNED July 8, 1955			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		7/10/55		TRINTY		ST MARY'S CITY MD.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
7/9/55		William S. Hauer		JOS. C. MATTINGLEY		LEONARDTOWN, MD.	

RECEIVED

JUL 14 1955

BUREAU V. 31

7048

item 9, Film 184 8-3-55 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY St. Marys		MARYLAND		STATE Maryland		COUNTY St. Marys	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN Leonardtwn				TOWN Leonardtwn X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				Rural			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(Type or Print)		(First) (Middle) (Last)		OF DEATH: 7 - 26 - 1955			
Audrey		Lynham		Clark			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
female	white	married	9 / 19 / 1920	34/33 yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Domestic		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John C. Lynham				Norma Halstead			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
4 no				----		George E. Clark, Jr. - Leonardtown, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 416X Ball Valve Thrombosis of Left Atrio						?	
ANTECEDENT CAUSE (S) Rheumatic Heart Disease						3 year	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
2							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov , 1952, to July 26 , 1955, that I last saw the deceased alive on July 25 , 1955, and that death occurred at 10:15 AM , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
Wendy Bay		Leonardtwn Md		7/26/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7/29/55		Fort Lincoln Cemetery		Washington, D.C.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
7-27-55		Clara D. House		P.B. Robinson - Leonardtown, Md.			

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 28 1955

RECEIVED

7049

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ST Mary's		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Leonardtown		LENGTH OF STAY (in this place) 1 day		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore, Md.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS St Mary's Hospital				STREET ADDRESS (If rural give location) 3V01-4			
3. NAME OF DECEASED: (First) (Middle) (Last) Laura V. Colgan				4. DATE (Month) (Day) (Year) OF DEATH: July 1, 1955			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: May 1883	9. AGE last birthday 72 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife			10B. KIND OF BUSINESS OR INDUSTRY: Home		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Benj. Ady				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) No		17. INFORMANT & ADDRESS: George Buckler Mechanicsville, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebrovascular hemorrhage						8 hours.	
ANTECEDENT CAUSE (S) DUE TO (B) Hypertensive Cardiovascular disease						5 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 7/5/55		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 25 June 1955 , to 1 July 1955 , that I last saw the deceased alive on 1 July 1955 , and that death occurred at 10:00 P.M. from the causes and on the date stated above.							
SIGNATURE Joseph E. Gill		M. D. Leonardtown, Md.		DATE SIGNED 1 July 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/5/55		NAME OF CEMETERY OR CREMATORY New Cathedral		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 7/11/55		REGISTRAR'S SIGNATURE Alan D. Hauer		24. FUNERAL DIRECTOR Jos. C. Mattingley		ADDRESS Leonardtown, Md.	

MARGIN RESERVED FOR BINDING

RECEIVED

JUL 7 1955

BUREAU V. S.

7050

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ST MARY'S		MARYLAND		STATE Maryland		COUNTY ST MARY'S	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN LEONARDTOWN		2DAYS		California TOWN LEONARDTOWN X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
78 ST MARY'S HOSPITAL				/			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last)			
DECEASED: (Type or Print)		INFANT		DEAN			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
FEMALE		WHITE		SINGLE		JULY 25, 1955	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
yrs.		Months		Days		Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				MARYLAND		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
CHESTER DAVID DEAN				ALICE ANN CECILIA LONG			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS:			
				MRS ALICE LONG CALIFORNIA, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
795.5 IMMEDIATE CAUSE (A) <u>Undetermined</u>						30 min.	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 24</u> , 1955, to <u>July 27</u> , 1955, that I last saw the deceased alive on <u>July 26</u> , 1955, and that death occurred at <u>3 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John H. Patrick</u>		ADDRESS <u>Lexington Park Ind.</u>		DATE SIGNED <u>July 28, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-28-55</u>		<u>St Joseph's</u>		<u>Morgans, Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
<u>7-28-55</u>		<u>Local Registrar</u>		<u>Joe C. Mattingly, Leonardtown, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 1 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7051
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

07052

Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ST MARY'S		MARYLAND		STATE MARYLAND		COUNTY P. Gen.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN LEONARDTOWN				TOWN BLADENSBURG 16-33-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS ST MARY'S HOSPITAL				STREET ADDRESS (If rural, give location) 4002 48th. ST.			
3. NAME OF DECEASED: (First) NELLIE (Middle) E. (Last) GASCH				4. DATE OF DEATH JULY 24 1955			
5. SEX: FEMALE		6. COLOR OR RACE: WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, MARRIED		8. DATE OF BIRTH: NOVEMBER 22, 1917	
9. AGE last birthday: 37 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY: HOME		11. BIRTHPLACE (State or foreign country): MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME: ANDREW F. CRANFORD				14. MOTHER'S MAIDEN NAME: VERA N. SAPP			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: ANDREW F. CRANFORD	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) Shock, hemorrhage							1 hour
DUE TO							
Antecedent cause(s) (b) Gun shot wound							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home		21c. (City or town) Galton Point (County) St. Mary's (State) MD		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY July 24 1955 8 AM.			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? self inflicted		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE J. Roy Gwyther			CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>				DATE SIGNED 7/24/55
23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL			DATE THEREOF 7/28/55		NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL		LOCATION (City, town, or county) SUTLAND MD. (State)
DATE REC'D BY LOCAL REG. 7/26/55			REGISTRAR'S SIGNATURE Glenn L. Hausel		24. FUNERAL DIRECTOR JOS. C. MATTINGLEY		ADDRESS LEONARDTOWN, MD.

RECEIVED

JUL 28 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

<div>7052</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</div> <div>Corrected cert. Film G184 7-28-55 See: Film of Orig: et</div> <div>CERTIFICATE OF DEATH</div> <div>Items 3, 4, 13, Film G184 8-4-55 et</div> <div>Reg. Dist. No. 281</div>											
1. PLACE OF DEATH:					2. USUAL RESIDENCE (HOME) OF DECEASED:						
COUNTY <u>St. Mary's</u> MARYLAND					STATE <u>Pennsylvania</u> COUNTY						
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>USNAS, Patuxent River</u>					CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Montrose</u>						
HOSPITAL OR INSTITUTION OR STREET ADDRESS					STREET ADDRESS (If rural give location)						
3. NAME OF DECEASED: (First) <u>Phillip</u> (Middle) <u>Lewis</u> (Last) <u>GRACE</u>					4. DATE (Month) (Day) (Year) OF DEATH: <u>July 22, 1955</u>						
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Caucasian</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>October 1, 1915</u>		9. AGE last birthday <u>39</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>USN</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>USN</u>			11. BIRTHPLACE (State or foreign country): <u>Scranton, Pennsylvania</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME: <u>Deceased James J. Grace, Sr.</u>					14. MOTHER'S MAIDEN NAME: <u>Lenora LYNCH</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes 13 yrs 9 mos to present</u>					16. SOCIAL SECURITY NO. <u>U. S. Navy Records</u>					17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION											
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH								INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>420.1 INFARCTION, MYOCARDIAL, ACUTE,</u>								Unknown			
ANTECEDENT CAUSE (S) DUE TO <u>Cause Unknown</u>											
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO											
(C)											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.											
19A. DATE OF OPERATION: <u>2</u>					19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OR INJURY street, office bldg., etc.)			21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>approximately 6:00 P.M.</u> , 19 <u>July</u> , to <u>26 July 1955</u> , that I last saw the deceased alive on <u>19 July</u> , and that death occurred at <u>Station Hospital</u> , <u>NAS PAX RIV MD</u> , M. D. <u>26 July 1955</u>											
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>			DATE THEREOF <u>7-26-55</u>			NAME OF CEMETERY OR CREMATORY <u>Station Hospital</u>			LOCATION (City, town, or county) (State) <u>Montrose, Pa.</u>		
DATE REC'D BY LOCAL REGISTRAR <u>7-26-55</u>			REGISTRAR'S SIGNATURE <u>P. J. Bean, M.D.</u>			FUNERAL DIRECTOR <u>Chambers Funeral Home, 1400 Chapin Street, N. W. Washington, D. C.</u>			ADDRESS		

RECEIVED

JUL 28 1955

BUREAU V. S.

7053

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ST MARY'S		MARYLAND		STATE MARYLAND		COUNTY ST MARY'S	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X RURAL ST MARY'S CITY		1 yr.		ST MARY'S CITY X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
EMMA SANNER GREENE				JULY 19, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
FEMALE	WHITE	WIDOW	10/6/1878	76 yrs.	9 Months	13 Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		HOME		MARYLAND		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
UNKNOWN				UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
NO		NONE		MRS CATHERINE MCKAY ST MARY'S CITY,			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Coronary Occlusion							
ANTECEDENT CAUSE (S) DUE TO (B) Coronary Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 16, 1955 , to 7-19-1955 , that I last saw the deceased alive on 7-16- , 19 55 , and that death occurred at 3:30 A M. from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS Dund Mill, Md.		DATE SIGNED 7-19-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		7/21/55		TRINTY		ST MARY'S CITY, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
7-19-55		[Signature]		JOS. C. MATTINGLEY		LEONARDTOWN, MD.	

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 21 1955
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

7054

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>ST. MARY'S</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ST. MARY'S</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>LEONARDTOWN</u>				OR TOWN <u>Mechanicsville</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ST. MARY'S HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Emma JANE Hayden</u>				OF DEATH: <u>July 21 1954</u>			
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>4-3-1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Domestic</u>		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>George T. Trice</u>				14. MOTHER'S MAIDEN NAME: <u>Julia Hobbs</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			16. SOCIAL SECURITY NO. <u>- - - - -</u>		17. INFORMANT & ADDRESS: <u>4404 - 36 Street</u> <u>Miss Elizabeth Hayden : South Arlington, Va.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Gastrointestinal Hemorrhage 2 d.</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Poss malignancy of g.i. tract</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (2608) DUE TO (C) <u>Enterobacteriaceae</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Staphylococcus aureus</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 15, 1954</u> to <u>July 21, 1954</u> , that I last saw the deceased alive on <u>July 21, 1954</u> , and that death occurred at <u>M. Mechanicsville</u> from the causes and on the date stated above.							
SIGNATURE <u>John E. Geyer</u>		M. D. <u>Mechanicsville</u>		DATE SIGNED <u>7/21/54</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7-23-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Joseph's CEMETERY</u>		LOCATION (City, town, or county) (State) <u>MORGANZA, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-22-55</u>		REGISTRAR'S SIGNATURE <u>Clarence House</u>		24. FUNERAL DIRECTOR <u>P.B. Robinson</u>		ADDRESS <u>LEONARDTOWN, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 25 1955

RECEIVED

7055

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH:

COUNTY

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

LENGTH OF STAY (in this place)

OR TOWN

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN

STREET ADDRESS

(If rural give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE OF DEATH:

(Month)

(Day)

(Year)

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

IMMEDIATE CAUSE

(A)

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1955 to July 9, 1955, that I last saw the deceased alive on July 9, 1955, and that death occurred at 12:00 PM, from the causes and on the date stated above.

SIGNATURE Roy G. Gopher M.D. ADDRESS New Carrollville DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY, OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

BUREAU V. S.

JUL 14 1955

RECEIVED

7056

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY St. Marys		MARYLAND		STATE Pennsylvania		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ronks			
X TOWN Mechanicsville				STREET ADDRESS (If rural give location) Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) Stephen		(Middle) B.		(Last) King		7 - 6 - 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
male	white	married	12 / 3 / 1883	71 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farming			10B. KIND OF BUSINESS OR INDUSTRY: farm owner		11. BIRTHPLACE (State or foreign country): Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Christian King				14. MOTHER'S MAIDEN NAME: Elizabeth Byler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) -----				16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS: Annie B. King - Ronks, Pennsylvania.	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332X IMMEDIATE CAUSE			(A) Hypostatic pneumonia				3 d.
ANTECEDENT CAUSE (S)			(B) Cerebral thrombosis				4 mos
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb , 19 55 , to July 6 , 19 55 , that I last saw the deceased alive on July 5 , 19 55 , and that death occurred at M , from the causes and on the date stated above.							
SIGNATURE Ray G. Guther		M. D.		ADDRESS Mechanicsville, Md		DATE SIGNED 7/1/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/9/55		NAME OF CEMETERY OR CREMATORY Beiler Amish Cemetery		LOCATION (City, town, or county) (State) Ronks, Pennsylvania.	
DATE REC'D BY LOCAL REGISTRAR 7-8-55		REGISTRAR'S SIGNATURE Glenn A. Hauser		24. FUNERAL DIRECTOR P.B. Robinson - Leonardtown, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 11 1955

BUREAU V. S.

7057

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ST MARY'S		MARYLAND		STATE MARYLAND		COUNTY ST MARY'S	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN RULEONARDTOWN		3 DAYS		RURAL COMPTON X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
78 ST MARY'S HOSPITAL				/			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
JULIA IARDELLA LORD				JULY 31, 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
FEMALE	WHITE	MARRIED	SEPTEMBER 8, 1884	70 yrs.	10 Months	23 Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
HOUSEWIFE				HOME		WASHINGTON, D.C.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
GABRIEL B. IARDELLA				ROSE KIERNAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
NO				NO		CHARLES E. LORD COMPTON, MD.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) DUE TO 420.1 Acute Pericardial Coronary Occlusion						20 hrs	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 30, 1955 , to July 31, 1955 , that I last saw the deceased alive on July 31, 1955 , and that death occurred at 12:00 P M , from the causes and on the date stated above.							
SIGNATURE Leonard B. G. D.				ADDRESS Leonardtown Md		DATE SIGNED 7/31/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		8/3/55		ROCK CREEK		WASHINGTON, D.C.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
8/1/55		Leonard B. G. D.		JOS. C. MATTINGLEY		LEONARDTOWN, MD.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 3 1955

RECEIVED

7058

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH: COUNTY ST MARY'S MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) LEONARDTOWN TOWN LEONARDTOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS ST MARY'S HOSPITAL				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ST MARY'S CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LEXINGTON PARK STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED: (Type or Print) INFANT NOLAND			4. DATE (Month) (Day) (Year) OF DEATH: JULY 11, 1955				
5. SEX: FEMALE	6. COLOR OR RACE: BLACK	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE	8. DATE OF BIRTH: JULY 2, 1955	9. AGE last birthday 9 yrs. 9 Months 9 Days 9 Hours 9 Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): MARYLAND			
13. FATHER'S NAME: LOUIS NOLAND		14. MOTHER'S MAIDEN NAME: ANN BARBER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: LOUIS NOLAND LEXINGTON PARK, MD.			
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Prematurity					9 days		
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 2, 1955 to July 11, 1955 that I last saw the deceased alive on July 11, 1955 , and that death occurred at 1:40 P.M. from the causes and on the date stated above.							
SIGNATURE H. Patrick		ADDRESS Lexington Park		DATE SIGNED 7-12-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 7/12/55		NAME OF CEMETERY OR CREMATORY ST. ALOYSIUS			
LOCATION (City, town, or county) (State) LEONARDTOWN, MD.		24. FUNERAL DIRECTOR ADDRESS JOS. C. MATTINGLEY LEONARDTOWN, MD.					
DATE REC'D BY LOCAL REGISTRAR 7/12/55		REGISTRAR'S SIGNATURE James D. H. Patrick					

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUL 14 1955

RECEIVED

7059

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <i>St Marys</i>	MARYLAND		STATE <i>md</i>	COUNTY <i>St Marys</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Chaptico</i>		
X TOWN <i>Leonardtown</i>	<i>6 1/2 hours</i>		STREET ADDRESS (If rural give location) <i>1</i>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>St Marys Hospital</i>					
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year) OF DEATH:		
<i>Infant Norris</i>			<i>July 9 1955</i>		
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <i>Infant</i>	8. DATE OF BIRTH: <i>July 8 - 1955</i>		
			9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. yrs. Months Days Hours Min. <i>6 3/4</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
			<i>Maryland St Marys</i>		<i>U.S.A.</i>
13. FATHER'S NAME: <i>John Norris</i>			14. MOTHER'S MAIDEN NAME: <i>Calma Grayson</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT & ADDRESS: <i>John L. Norris Chaptico Md</i>		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
776 X IMMEDIATE CAUSE (A) <i>Prematurity</i>		
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from *July 8, 1955* to *July 9, 1955*, that I last saw the deceased alive on *July 9, 1955* and that death occurred at *4:45* M, from the causes and on the date stated above.

SIGNATURE <i>J. M. St. Patrick</i>	ADDRESS <i>M. D. Lexington Park Md.</i>	DATE SIGNED <i>July 9, 1955</i>
------------------------------------	---	---------------------------------

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>7/10/55</i>	NAME OF CEMETERY OR CREMATORY <i>St Albans</i>	LOCATION (City, town, or county) (State) <i>Leonardtown Md</i>
--	-----------------------------	--	--

DATE REC'D BY LOCAL REGISTRAR <i>7/9/55</i>	REGISTRAR'S SIGNATURE <i>William D. House</i>	24. FUNERAL DIRECTOR <i>John C. Mattingly</i>	ADDRESS <i>Leonardtown Md</i>
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 14 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07061
7060 CERTIFICATE OF DEATH Reg. Dist. No. 251

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>St. Mary's</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>St. Mary's</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Patuxent River</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lexington Park Lakeland 48X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Station Hospital, U.S. Naval Air Station</u>		STREET ADDRESS (If rural give location) <u>Rt. 2 Box 75 952 (see birthcert)</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Robin</u>	(Middle) <u>Lynn</u>	(Last) <u>O'DONIEL</u>	(Month) <u>July</u> (Day) <u>2</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>July 2, 1955</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
yrs. <u>4</u> Months <u>4</u> Days <u>4</u> Min.		<u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William Frank O'DONIEL</u>		14. MOTHER'S MAIDEN NAME: <u>Alice PRINCE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		<u>Hospital Records</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Anoxia due to atelectasis</u>			<u>4 hrs.</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
2. I hereby certify that I attended the deceased from <u>2 July, 1955</u> to <u>2 July, 1955</u> , that I last saw the deceased alive on <u>2 July, 1955</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>S. Cassara, LCDR MC USNR</u>		DATE SIGNED <u>7-5-55</u>	
ADDRESS <u>Station Hospital, M. D. USNAS, PAX RIV MD.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-5-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>		LOCATION (City, town, or county) (State) <u>Great Mills, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-5-55</u>		REGISTRAR'S SIGNATURE <u>pg Beams MD.</u>	
		24. FUNERAL DIRECTOR <u>U. S. Navy Patuxent River, Md.</u>	
		ADDRESS <u>Local Registrar</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 7 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07062
7061 CERTIFICATE OF DEATH Reg. Dist. No. 287

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St. Mary's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>NAS, Patuxent River</u>		<u>1 day</u>		OR TOWN <u>California</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Station Hospital</u>				STREET ADDRESS (If rural give location) <u>c/o C. B. Messick</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Deborah Louise REDDING</u>				<u>July 29 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>Caucasian</u>	<u>Single</u>	<u>July 28, 1955</u>	<u>0 yrs.</u>	<u>Months</u>	<u>Days</u>	<u>Hours</u> <u>Min.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Ben Dwight REDDING</u>				<u>Elizabeth Lou MESSICK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<u>Mother: California, Maryland</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Congenital Pneumothorax</u>						<u>24 hrs</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>2</u>							
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
2. I hereby certify that I attended the deceased from <u>7-28</u> , 19 <u>55</u> , to <u>7-29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7-29</u> , 19 <u>55</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE		S. CASSARA, LCDR MC USNR		ADDRESS		DATE SIGNED	
<u>Sam Cassara</u>		<u>Station Hospital</u>		<u>NAS Patuxent River, Md.</u>		<u>7-29-55</u>	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-1-55</u>		<u>Old Fields Church</u>		<u>Hughesville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>8-1-55</u>		<u>P. B. Robinson</u>		<u>P. B. Robinson</u>		<u>Leonardtown, Md.</u>	
<u>2095191333</u>							

RECEIVED

AUG 4 1955

BUREAU V. S.

MAILED
COMM-FBI

7062

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>St. Marys</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>St. Marys</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Leonardtown, Md</i>		5 DAYS		OR TOWN <i>Leonardtown</i> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>St. Marys Hosp</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>Herbert Sherkliff</i>				OF DEATH: <i>July 23 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
MALE	COLORED	SINGLE	OCTOBER 15, 1884	70 yrs.	9 Months	8 Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
COOK						MARYLAND	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
JAMES SHERKLIFF				PHOEBE LANDLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
NO				NONE		JOS. BUCHANAN LEONARDTOWN, MARYLAND	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Ca of Large intestine</i>							<i>6 months</i>
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							<i>Rheumatoid arthritis severe</i>
19A. DATE OF OPERATION: <i>0</i>							20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
19B. MAJOR FINDINGS OF OPERATION							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		
					INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>October 7, 1954</i> , to <i>July 23, 1955</i> , that I last saw the deceased alive on <i>July 22, 1955</i> , and that death occurred at <i>2 A. M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>W. H. B. B.</i>				ADDRESS <i>Leonardtown Md</i>		DATE SIGNED <i>7/23/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		7/26/55		ST ALOYSIUS		LEONARDTOWN, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR <i>7/26/55</i>		REGISTRAR'S SIGNATURE <i>Glenn D. Hauser</i>		24. FUNERAL DIRECTOR		ADDRESS	
				JOS. C. MATTINGLEY		LEONARDTOWN, MD.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 28 1955

BUREAU V. S.

7063

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY St. Marys		MARYLAND		STATE Maryland		COUNTY St. Marys	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN California			
X TOWN Leonardtwn				STREET ADDRESS (If rural give location) Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS St. Marys Hospital							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Mary Sommerfield				7 - 1 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
female	colored	widowed	2 / 14 / 1878	77 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
housewife			Domestic	Maryland		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Samuel Thomas				Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
no						Carrie Smith - California, Md.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
331X				Cerebral Hemorrhage		6/27/55	
ANTECEDENT CAUSE (S)				(B) DUE TO		Next years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				Generalized Arteriosclerosis			
				(C) DUE TO			
				Uremia			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/28 , 19 55 , to 7/1 , 19 55 , that I last saw the deceased alive on 7/1 , 19 55 , and that death occurred at 8:20 PM , from the causes and on the date stated above.							
SIGNATURE Robert V. Fuchs				ADDRESS Leonardtwn, St. Marys, Md.		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7/5/55		Holy Face C emetery		Great Mills, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
7-5-1955		Wm. D. Hanner		P.B. Robinson - Lepnardtown, Md.			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 6 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7064

07065

Reg. Dist. No. 282

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St. Marys</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Marys</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Mechanicsville</u>				TOWN <u>Mechanicsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>Rural</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u>		(Middle) <u>Lantz</u>		(Last) <u>Stoltzfus</u>		(Month) (Day) (Year) <u>7 - 4 - 1955</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>male</u>		<u>white</u>		<u>married</u>		<u>23 July 1900</u>	
9. AGE last birthday:		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>54</u> yrs.		<u>farming</u>		<u>Farm owner</u>		<u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME:					
<u>USA</u>		<u>Stephen F. Stoltzfus</u>					
14. MOTHER'S MAIDEN NAME:		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)					
<u>Susan Lantz</u>		<u>no</u>					
16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:					
		<u>Hanna Stoltzfus - Mechanicsville, Md.</u>					
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) <u>Arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>none</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
<u>none</u>							
20. AUTOPSY?				21. HOW DID INJURY OCCUR?			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)	
<u>none</u>				<u>none</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<u>none</u>				<u>none</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE							
<u>[Signature]</u> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7/6/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> M. D.							
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-7-55</u>		<u>Amish-Menonite Cemetery</u>		<u>Mechanicsville, Md.</u>	
DATE REC'D BY LOCAL REG.		24. FUNERAL DIRECTOR ADDRESS					
<u>7-7-55</u>		<u>[Signature]</u> <u>P.B. Robinson - Leonardtown, Md.</u>					

BUREAU V. S.

MAR 8 1955

RECEIVED

7065

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY St. Mary's		MARYLAND		STATE New York Maryland		COUNTY St. Marys	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Scotland, Box 11			
X TOWN Leonardtwn				TOWN Ellensville 69X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS St. Mary's Hospital				STREET ADDRESS (If rural give location) 5 1/2 Church St.			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		5. SEX:		6. COLOR OR RACE:	
DECEASED: (Type or Print) Infant Boy Taff		OF DEATH: July 5 1955		Male		White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single		8. DATE OF BIRTH: July 5, 1955		9. AGE last birthday yrs. 5		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Loren M. Taff				14. MOTHER'S MAIDEN NAME: FRANCES M. DAVIS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Theodore J. Taff :: Michigan			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Heart failure							
ANTECEDENT CAUSE (S) DUE TO (B) Premature newborn							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7-5 , 19 55 , to 7-1 , 19 55 , that I last saw the deceased alive on 7-5 , 19 55 , and that death occurred at 9:30 P. M, from the causes and on the date stated above.							
SIGNATURE Heis Purpura		ADDRESS St. Mary's Hospital		DATE SIGNED 7-6-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-6-55		NAME OF CEMETERY OR CREMATORY St. Aloysius Cemetery		LOCATION (City, town, or county) (State) Leonardtwn, Maryland	
DATE REC'D BY LOCAL REGISTRAR 7-6-55		REGISTRAR'S SIGNATURE Claw D. Lawrence		24. FUNERAL DIRECTOR P. B. Robinson :: Leonardtown, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 2 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7066

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 281

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St Mary's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St Mary's</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Bushwood</u>		<u>13 years</u>		TOWN <u>Bushwood</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>James</u>		(Middle) <u>Walter</u>		(Last) <u>Tyer</u>		July 28 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Aug 15 - 1893</u>	9. AGE last birthday: <u>61</u>		IF UNDER 1 YEAR	
					Months <u>11</u> Days <u>17</u> Hours <u>14</u> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>labor by week</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland St Mary's</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9</u>		16. SOCIAL SECURITY No.: <u>213-36-2099</u>		17. INFORMANT & ADDRESS: <u>L.M. Bailey, River Springs Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Accidental Drowning</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>1/2 hour</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Epilepsy</u>						<u>50 years</u>	
19a. DATE OF OPERATION: <u>7-30-55</u>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg, etc.) <u>White Oak Creek</u>		21c. City or town (County) <u>Bushwood St Mary's Md</u>		21d. TIME (Month) (Day) (Year) (Hour) <u>July 28/55 2 P.M.</u>	
21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>While crawling he had epileptic attack</u>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/28/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>7-30-55</u>		NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		LOCATION (City, town, or county) (State) <u>Bushwood Maryland</u>	
DATE REC'D BY LOCAL REG. <u>July 28/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Leonardtown Md</u>	

BUREAU V. 2

AUG 1 1955

RECEIVED

7067

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ST. MARY'S		MARYLAND		STATE MARYLAND		COUNTY ST. MARY'S	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN RURAL HOLLYWOOD		10 YRS.		TOWN RURAL HOLLYWOOD X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
JANE RODGERS UNDERWOOD				JULY 5 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
FEMALE	WHITE	MARRIED	OCTOBER 15, 1876	78 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		HOME		PENNSYLVANIA		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
JACOB D. RODGERS				LOTTIE JOHNSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
NO		161-16-2617B		HOWARD W. UNDERWOOD HOLLYWOOD, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Coronary Heart Failure						178.	
ANTECEDENT CAUSE (S) (B) Arteriosclerotic heart disease						104	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Severely atherosclerotic						102	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
none							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
none		none		none			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While Not while at work at work		21F. HOW DID INJURY OCCUR?			
none		at work		none			
22. I hereby certify that I attended the deceased from June 1, 1955 , to July 5, 1955 , that I last saw the deceased alive on July 1, 1955 , and that death occurred at 10 P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
[Signature]		West Laurel Hill		7/6/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
CREMATION		7/8/55		West Laurel Hill		West Phila	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
7-6-55		[Signature]		JOS. C. MATTINGLEY		LEONARDTOWN, MD.	

MARGIN RESERVED FOR BINDING

RECEIVED

JUL 11 1955

BUREAU V. S.

7068

CERTIFICATE OF DEATH

Reg. Dist. No. 202...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ST MARY'S		MARYLAND		STATE MARYLAND		COUNTY ST MARY'S	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN LEONARDTOWN		3 days		TOWN PINEY POINT X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS ST MARY'S HOSPITAL				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
MARY KATHLEEN YINGST				JULY 2, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
FEMALE	WHITE	MARRIED	8/15/1907	47 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE			HOME		MARYLAND		U.S.A.
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
WARREN J. ADAMS				MARY B. PERCELL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
X NO (If Yes, give war or dates of service) NO		LOST		WILLIE E. YINGST PINEY POINT, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Carcinoma of uterus and bladder						1 year	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from June 23, 1955 , to July 2, 1955 , that I last saw the deceased alive on July 1, 1955 , and that death occurred at 2:30 AM , from the causes and on the date stated above.							
SIGNATURE [Signature]		M. D. [Signature]		ADDRESS [Signature]		DATE SIGNED July 2/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		7/5/55		ST GEORGE'S		VALLEY LEE, MD.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
July 2/55		[Signature]		JOS C. MATTINGLEY		LEONARDTOWN, MD.	

MARGIN RESERVED FOR BINDING

RECEIVED

JUL 7 1955

BUREAU V. S.